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ABSTRACT

Research on therapeutic factors of group psychotherapy for adult alcoholics is reviewed. The research in this area has focused on determining whether or not group psychotherapy is an effective treatment modality for alcoholics. This review examines therapeutic factors in three phases of treatment: (1) preadmission, (2) primary intervention, and (3) aftercare. Treatment matching, orientation groups, and interactional group psychotherapy are the main factors examined. A special population, patients' attribution of change, advice or extended treatment, and patients' personal construct changes are also examined. The research suggests that treatment outcome is affected by the type of intervention employed during all phases of treatment, and that treatment matching, orientation groups, and transition groups all appear to improve treatment outcome. Treatment for alcoholism appears to be moving away from the use of similar interventions with all alcoholic patients toward patient-treatment matching. Further study of treatment matching is recommended to enable providers to maximize treatment efficacy. Contains 71 references. (Author/JBJ)

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FACTORS OF GROUP PSYCHOTHERAPY FOR ADULT ALCOHOLICS: A LITERATURE REVIEW

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A Doctoral Research Paper
Presented to
the Faculty of the Rosemead School of Psychology
Biola University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Psychology

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by
Jonathan K. Howard
May, 1996

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ABSTRACT

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Research on therapeutic factors of group psychotherapy for adult alcoholics is reviewed. The research in this area has focused on determining whether or not group psychotherapy is an effective treatment modality for alcoholics. This review examines therapeutic factors in three phases of treatment: (a) preadmission, (b) primary intervention, (c) and aftercare. Treatment matching, orientation groups, and interactional group psychotherapy are the main factors examined. A special population, patients' attribution of change, advice or extended treatment, and patients' personal construct changes are also examined. The research suggests that treatment outcome is affected by the type of intervention employed during all phases of treatment, and that treatment matching, orientation groups, and transition groups all appear to improve treatment outcome. Directions for future research are suggested.

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FACTORS OF GROUP PSYCHOTHERAPY FOR ADULT ALCOHOLICS: A LITERATURE REVIEW

Introduction

Group psychotherapy with adult alcoholics is a treatment modality found in many recovery programs. Research in this area has focused on determining whether or not group psychotherapy is an effective treatment modality for alcoholics. However, relatively little attention has been paid to the therapeutic factors which contribute to or detract from this mode of treatment for alcoholics. Rather, implications and hypotheses for future research were often inferred from more general research.

The aim of this review is to examine the published empirical research concerning therapeutic factors which contribute to or detract from group psychotherapy for alcoholics. This review is limited to studies which examined factors related to the use of group psychotherapy with alcoholics in general or with specific subgroups of alcoholics. Studies examining group psychotherapy with a more general population of substance abusing patients were excluded. The studies are presented in three categories: preadmission treatment factors, primary intervention treatment factors, and aftercare treatment factors.

Many of the studies were conducted within programs where group psychotherapy was only one element of the treatment.

Often, the researchers did not identify which of the concurrent treatment elements produced which results. This creates significant concern regarding the internal validity of these studies and generalization should be cautious.

Therapeutic factors of support group therapy such as Alcoholics Anonymous (AA) and family or couple therapy with this population have been previously reviewed (Galaif & Sussman, 1995; O'Farrell, 1989; Thomas, 1989), and will not be examined in this paper. Factors associated with pharmacological interventions are also beyond the scope of this review.

Preadmission Treatment Factors

Although there is existing literature that illustrates the power of orienting a patient to the process of therapy (Garfield, 1978; Lorion, 1978), few studies have investigated the effect of pretreatment care as a factor in alcoholics' responses to intervention.

Inpatient Preadmission Treatment

Conti and Verinis (1989) conducted a study examining the effect of an outpatient preadmission participation program on the subsequent behavior of 65 inpatients on an alcohol treatment unit which utilized group and individual psychotherapy. It was hypothesized that the preadmission patients would have partially acclimated to the program and would make a better adjustment in treatment compared to patients transferred from other units in the hospital without preadmission exposure to the inpatient alcohol unit.

The study consisted of 43 patients admitted from

outpatient pre-bed care and 22 directly transferred from other units of the medical center. They were primarily Black (65%), middle aged (M = 42.8, SD = 11.32), unemployed (71%), and divorced or separated (56%) with an 11-year average history of problem drinking. The two groups did not significantly differ on any of the demographic variables.

Patients in the study were administered the Brief Symptom Inventory (Derogatis, & Melisaratos, 1983), a self-report scale focusing on psychiatric symptomatology. Their behavior on the ward was rated by the unit social worker using the Charles MacAndrew Behavioral Adjustment Scale (MACC) which was developed by Ellsworth (1970). It was also rated by their group therapist using the Brief Psychiatric Rating Scale (Overall & Gorham, 1962). All ratings were taken on the 2nd, 8th, 16th, and 24th days of hospitalization. Patients and raters were blind to the study's purpose. Patients were also interviewed to gather demographic information and drinking history and pattern. Scores on the three psychiatric symptomatology scales were analyzed using t tests for noncorrelated observations (Winer, 1962). Comparison of inpatient program completion rates for patients who received preadmission treatment and those who did not were made using the proportion of difference test (Dixon & Massey, 1957).

The groups were found to be indistinguishable from each other on the self-reported measure of psychiatric symptomatology (Brief Symptom Inventory), the social worker-rated measure of behavior on the ward (MACC Behavior Adjustment Scale), and the therapist-rated measure of psychopathology (Brief Psychiatric Rating Scale). If pre-bed

care had an effect on behavior during inpatient treatment, it was not measured by any of the instruments used in this study. The possibility exists that the rating scales were unable to differentiate more subtle differences between the two groups.

Only 7% of the pre-bed care patients left the program against medical advice (AMA), as compared to 32% of the direct transfer patients. This comparison reached clinical significance at the .05 level. Comparisons of pre-bed care (46%) and direct transfer patients (22%) with regard to attending the aftercare clinic during the 6 months following discharge was not statistically significant. However, significantly more pre-bed care patients (23%) than direct transfer patients (9%) were still active in aftercare beyond 6 months ($p < .05$).

Conti and Verinis (1989) suggested that pre-bed care provided an orientation to the treatment staff, facility, and milieu. Patients appeared to be able to evaluate the treatments offered and to work through any related ambivalence during this time. The researchers further recommended against direct transfers from a medical ward and suggested that pre-bed care may be a cost-effective way to prevent aborted admissions.

Generalizations from these results and recommendations are tenuous because the specifics of the daily pre-bed treatment were not completely described and included an unidentified number of AA meetings within the community. The effect of outside AA meetings on the results and the differential effects of group and individual therapy were not considered.

A possible confounding variable in this study may be the longer stay in the hospital by the direct transfer patients. These patients initially sought treatment for their medical condition and may have been less motivated than patients initially seeking treatment for their alcohol abuse/dependence. Therefore, the researchers' conclusions should be accepted without generalization to other populations.

Day Treatment Preadmission Treatment

Alterman, Bedrick, Howden, and Maany (1994) wanted to see if the retention in treatment of patients who attended an orientation group (OG) which met for 1 hour 3 days per week would be superior to those placed on a waiting list (WL) prior to a day treatment program. The treatment program used group psychotherapy, with some of the patients also receiving individual counseling. The components of the group treatment and the rationale for some group members to receive individual counseling were not given. Participants were not randomly assigned to the treatment groups or evaluated concurrently. Rather, the study took advantage of a program change and was conducted to evaluate the different experiences. Patients were assigned to the WL group during the 6 months prior to implementation of the orientation group and to the OG group during the 6 months following its implementation.

The Addiction Severity Index (ASI), developed by McLellan, Luborsky, Woody, and O'Brien (1980), was administered by a trained research technician to all patients as part of their intake. It provided basic sociodemographic information, including the severity of drug and alcohol abuse,

medical, legal, employment, psychiatric, and family/social problems. Two indices were derived: (a) the interviewer severity rating, a measure of the interviewer's assessment of severity of the patient's problems in a particular area, and (b) a composite score, a numerical rating of problem severity derived directly from the information gathered. Additional program data was gathered from clinical records. The data were analyzed for the entire group as well as separately for the alcohol- and cocaine-dependent patients in each treatment condition. Bivariate analyses were conducted to compare the OG and WL groups on sociodemographics, recent substance abuse histories, and rates of program completion.

The results indicated that the groups did not differ significantly on basic sociodemographics. They were similar as well on most of the measures of the ASI. However, during the 30 days prior to intake, the 29 patients in the OG alcohol subsample reported significantly more days of alcohol use, more days intoxicated, a higher ASI alcohol composite score, and more days troubled by psychiatric problems as compared to alcoholic patients in the WL condition ($p < .03$). These findings suggest that the severity of addiction was worse over time among patients in the orientation group.

The results showed that fewer patients from the OG treatment group entered the day treatment program than patients from the WL treatment ($p < .05$). There was no significant difference in day treatment completion rates between the WL condition patients (50.9%) and the OG patients (58.6%). Neither was there a significant overall difference in day treatment program completion rates for patients assigned

at intake to the WL (40.6%) and OG treatments (40.1%).

To partial out the possible effects of any variables on which the groups differed at baseline, the preceding analyses were repeated using analyses of covariance for continuous outcome variables and logistic regression for dichotomous outcome variables. However, the findings remained unchanged.

Alterman et al. (1994) identified a number of limitations in their study. First, the study did not use an experimental design in which patients were assigned on a random basis to one of several concurrent treatments. Second, the study was quasi-experimental in that it took advantage of a program change that occurred over time. This prohibited controlling for patient and staff characteristics or clinic procedures which may have varied over time. Future research could examine the difference between WL treatment and OG treatment during the same time period, once the program changes had been implemented. The researchers also stated that the findings should be generalized tentatively beyond the type of individuals studied: lower socioeconomic male veterans. Researchers emphasized that it is possible for an individual group member to respond differently to the treatment conditions than did the group as a whole.

To decrease the threat of interaction of testing and treatment, future research could include administration of the ASI at the beginning of the day treatment program. This additional rating could help determine if the OG treatment led to greater psychological stress and a concomitant increase in substance use. Another consideration for future research would be to increase the frequency of meetings for the orientation

group to five days per week. Such a change would be hypothesized to increase the percentage of patients who completed the orientation group and went on to complete the treatment program.

In summary, results do not suggest that pre-bed or orientation treatment will result in more compliant behavior or increased completion of treatment programs. However, the research does support the theory that considerable patient attrition takes place in the early phase of treatment. Although patients may not behave differently or remain in treatment longer, the quality of their treatment program may differ. Also, those patients who go on from orientation/pre-bed care are significantly more likely to continue longer in their recovery than those who do not.

In terms of the clinical application of these findings, preadmission care and orientation groups appear to be beneficial in allowing patients a window of time during which they may assess the treatment offered. Pretreatment appears to be a positive factor in screening ambivalent patients, providing them with time for detoxification, and decreasing attrition during the treatment phase.

Primary Intervention Treatment Factors

Research has been done to identify the outcome of group psychotherapy for alcoholics (Brandsma & Pattison, 1985). However, the research did not identify the types of interventions which either contribute to or detract from group therapy with this population. This section reviews the research which examined treatment-matching factors,

interactional group psychotherapy, special population treatment, patients' attribution of change, advice or extended treatment, and patients' personal construct changes.

Treatment Matching

Oei and Jackson (1980) hypothesized that improving social skills may lead to a decrease in alcohol consumption. This hypothesis was based on research findings which have identified social skills training (SST) as effective in improving individual repertoires of social behavior as well as self-reported satisfaction with social performance. However, this research lacked measures of symptomatology reduction and did not assess long-term effects (Galassi, Galassi, & Litt, 1974; McFall & Twentyman, 1973). In addition, there were no studies that assessed whether or not SST conducted in group was superior to individual SST training.

Oei and Jackson (1980) believed the group setting would more effectively replicate the social setting in which alcoholics would be called on to utilize SST techniques. They investigated: (a) whether SST group training resulted in greater retention of therapeutic gain over time than individual training, and (b) whether SST resulted in more significant reductions in alcohol consumption as compared to traditional supportive therapy (TST) with groups or individuals.

Thirty-two chronic alcoholics (8 women and 24 men) treated at an inpatient treatment center were equally divided into four groups with 8 members assigned to each of the following groups: group SST, individual SST, group TST, and individual TST. Patients were also distributed evenly

according to mean daily alcohol consumption and mean score on an assertiveness and social skills inventory. The same doctoral student and psychiatric nurse served as therapists, both having at least 3 years experience in the cognitive-behavioral technique employed in the study.

The SST group was trained in the areas of nonverbal expression (e.g., eye contact), refusing unreasonable requests, making difficult requests, expressing and receiving positive feelings, replying to criticism, and initiating conversations. Each session involved a short lecture regarding treatment rationale, modeling of skills by the therapists, and videotaped role-plays involving therapists and patients. The videotaped role-plays were viewed in session for corrective feedback by therapists and other group members. Two sessions were devoted to each of the six major skills. Individual SST treatment involved individuals watching the tapes made of the group sessions in the company of an individual therapist without the benefit of interaction with the group. The same therapists who conducted the groups acted as individual therapists

The TST group was described to the patients as interaction which would release their social skills through "mentally exploring themselves" with the therapists' assistance. The problems discussed were initiated by the clients themselves and centered around marital and monetary concerns. Individual TST involved the same treatment with therapists attempting to retain similar attitudes and cover similar topics as in the TST group treatment.

The treatments involved twelve sessions over a period of

3 weeks with group sessions lasting 2 hours and individual sessions lasting 1 hour. The assessment of the patients included self-report and behavioral measures with data collection taking place pretreatment, posttreatment, and at 3-, 6-, and 12-month follow-ups.

Patients underwent a behavioral interview with a clinical psychologist, who was blind to the nature of the study, 7 days after admission to treatment and again 12 months after discharge. The interviewer and two trained psychiatric nurses rated the patients on a 5-point scale across 11 categories of social skills. Patients also completed an alcohol intake inventory assessing consumption during the 7 days prior to admission and the Behavioral Assertion Scale (Alberti & Emmons, 1975). The Social Interaction Scale, with subscales of Social Avoidance and Distress and Fear of Negative Evaluation, developed by Watson and Friend (1969), and the Eysenck Personality Questionnaire were also completed. A three-way ANOVA with one repeated measure was applied to each of the dependent measures (interviewer's rating, nurses' rating, alcohol intake inventory, Behavioral Assertion Scale, Social Interaction Scale, and Eysenck Personality Questionnaire) to test for the main effects of group versus individual training conditions, social skills versus traditional supportive therapy, the time, and their interactions.

The average age of the chronic alcoholic sample was 33.5. They had an average of 1.6 previous inpatient admissions for treatment of alcoholism. Analyses indicated that the SST patients showed less alcohol consumption than the TST patients ($p < .01$). No main effect was evident for group or individual

therapy. The nurses' ratings showed a significant difference in assertiveness, with the SST group therapy patients producing a greater increase in assertiveness as compared to the TST group therapy patients ($p < .01$). Results from the social interaction scale, when evaluated with both subscales, indicated that the SST group patients most quickly improved their ratings of Social Avoidance and Distress compared to the other 3 groups ($p < .01$) which showed almost no improvement across time. In terms of the three subscales of the Eysneck Personality Questionnaire (Emotionality, Impulsivity, and Extroversion), the SST patients became much less emotional and impulsive, and more extroverted than patients in the TST groups ($p < .01$). According to the behavioral self-rating, the SST therapy patients reported increases in their assertiveness, with group therapy patients reporting faster increases as compared to individual treatment patients. Scores on the Behavioral Assertion Scale also showed significant differences, with the SST group patients reporting greater improvement in assertiveness than patients in SST individual ($p < .01$). There was almost no improvement in self-report of assertiveness over time among the TST treatment conditions.

These results suggest a benefit from the group therapy environment for cognitive-behavioral social skills learning as compared to individual skills learning. However, caution should be employed in comparing SST with TST. The goal of TST was presented as releasing their social skills which appears at face value to be different from the goal of support usually ascribed to TST. Therefore, it appears questionable to say that TST is an adequate alternative method of coping skills

training. The most that may be safely concluded from this research is that group SST is superior to individual SST, and that with the goal of social skills training as defined above, SST is superior to TST. Additionally, the low statistical power created by such few patients threatens this study's validity.

Rohsenow et al. (1991) used treatment-matching of alcoholics in their study based on social learning theory. They hypothesized that communication skills training (CST) and cognitive-behavioral mood management training (CBMMT) could improve alcoholics' adaptive responses to high-risk circumstances which occur in interpersonal and negative affect situations (Marlatt & Gordon, 1985). Alcoholics who demonstrated high skill or low anxiety in alcohol-specific role-plays were expected to benefit from CST, while alcoholics demonstrating low skill, more irrational beliefs, or greater urge to drink in these role-plays were expected to benefit more from CBMMT. Two other hypotheses were examined: (a) alcoholics with higher education were expected to benefit more despite treatment condition, and (b) alcoholics who scored lower on a measure of alcohol dependence were expected to have better outcomes.

Cohorts of 6 to 10 patients were randomly assigned to one of three treatment groups: communication skills training (CST), communication skills training group with a family member, or close friend participating (CSTFG), or cognitive behavioral mood management training (CBMMT). The CST and CSTFG groups were trained for both general and alcohol-specific situations. Training included: assertiveness, initiating

conversations, listening skills, giving and receiving compliments and criticism, enhancing close relationships, drink refusal training, handling criticism about drinking, and enhancing nonalcoholic social support networks. The CBMMT group training, designed to cope with negative emotions and desires to drink, included cognitive restructuring, relaxation training, and stimulus control. Specific training included deep muscle relaxation, challenging and replacing cognitions that lead to negative affect or desire to drink, identifying situations that trigger drinking, and forming a plan to handle high-risk situations using avoidance or substitution strategies.

Outcomes were measured using the Time-Line Follow Back interview. The Alcohol Dependence Scale developed by Skinner and Allen (1982) was used to measure the severity of alcohol dependence. The Irrational Beliefs Test, developed by Jones (1968), associated with negative mood and trait anxiety, assesses the 10 domains of dysfunctional beliefs proposed by Ellis (1962).

Multiple regression was used to test the significance of the main effects and interaction terms. In each regression equation, the dependent variable was the drinking rate during the 6 months of follow up. The pretreatment drinking rate was entered as one of the covariates. Pearson correlations were calculated for the various matching variables in order to determine the degree of colinearity.

Group comparisons indicated that the CST group drank significantly less than the CBMMT group ($p < .02$). patients in the CBMMT treatment with less education drank more than

patients with more education ($p < .03$). They also drank more than patients as a whole in the CST treatment ($p < .03$). CBMMT patients with higher anxiety at pretreatment drank significantly more during follow up than CBMMT patients with lower anxiety at pretreatment ($p < .03$). Patients in CST and CSTFG did equally well regardless of levels of pretreatment anxiety ($p < .05$). Patients in CBMMT who scored higher in urge to drink during the pretreatment role-plays drank significantly more during follow up than did CBMMT patients who scored lower in initial urge to drink ($p < .02$). Patients in CST and CSTFG did equally well regardless of pretreatment urge to drink. Additionally, analyses of behaviorally-rated skill in role-plays, Irrational Belief Test total scores, marital status, and Alcohol Dependence Scale total scores did not result in any significant main or interaction effects.

Since anxiety and urge to drink during the role-play were found to significantly correlate ($p < .006$), another multiple regression was conducted. Urge to drink during role-play, anxiety during role-play, and education were found to be independent and effective in predicting mean number of drinks and percent of days abstinent during follow up ($p < .05$).

Rohsenow et al. (1991) concluded that CST appeared to be equally effective for alcoholics regardless of education, pretreatment coping skill, anxiety in high-risk role plays, alcohol dependence, or marital status. Conversely, the more cognitively-oriented CBMMT only benefited alcoholics with higher education, possibly due to the complex nature of cognitive abilities necessary for cognitive-behavioral treatment. CBMMT was least successful in reducing the drinking

rate among alcoholics with less education, more anxiety, and more urge to drink during role plays at pretreatment.

Another unexpected result was that patients with greater anxiety benefited less from CBMMT, even though it emphasized anxiety-reduction techniques. It was hypothesized by the researchers that anxiety may have interfered with learning these cognitive techniques, and as a result, the more interpersonal nature of the CST proved a better treatment match for those with high anxiety. Patients with high urge to drink during role-play also found the interpersonal nature of CST more productive in developing an effective coping style.

Some observations should be made with regard to the validity of this research. It appears that CBMMT does not affect the mood management construct it was intended to change. It would be helpful to compare the outcomes of CST with those of other interventions designed to address mood management. It would also be helpful to compare the predictor variables examined with other variables or personality factors which have been found to be effective in evaluating treatment-matching designs.

Another observation about this research is that CST, CSTFG, and CBMMT were added to an inadequately described core treatment program. Potential interactions of the core treatment program with CST, CSTFG, and CBMMT need to be assessed. It was unclear how many patients volunteered for treatment and how many were ordered (by court or family) to participate. Generalizations should be limited to similar patients in similar inpatient programs.

In summary, the studies regarding treatment-matching of

patients with group psychotherapy as a primary intervention have suggested a number of important treatment factors to be considered in clinical application. The group setting was found to be more effective than individual therapy for social skills training. Also, social skills training appears to be better than traditional support therapy for the development of social skills. Social skills training also appears helpful in decreasing alcohol consumption and impulsivity. The experience and expression of emotionality as well as extroversion and assertiveness appear to increase as a result of SST. These contributions clearly establish social skills training as a beneficial treatment with an alcoholic population.

CST was identified as a helpful treatment component. It was more helpful than CBMMT in lowering alcohol consumption. Specifically, CST appeared to be better for patients with high anxiety, high urge to drink and low skill in the drink refusal role-play. However, CBMMT appeared helpful for patients with high education, low anxiety, or both at the time of pretreatment role-plays. In future examinations of mood management and communication skills training, other mood management treatments may prove more effective than CBMMT.

Interactional Group Psychotherapy

Brown and Yalom (1977) evaluated three long-term (at least one year) interactional therapy groups of recovering alcoholics. In their study they examined factors of group therapy with alcoholics which might differ or need to be altered in comparison to factors of group psychotherapy with neurotics. Their results were presented both as a case study and an empirical study. The control of drinking was an overall

goal for the alcoholics. However, the focus of the group was not to facilitate or establish abstinence among members, but to help members overcome the conflicts which lead to compulsive drinking through intense focus on the interpersonal pathology which led to their maladaptive drinking behavior. The investigators assumed that specific mechanisms of change were available in the intensive group experience, with the major mechanisms being: interpersonal learning, group cohesiveness, existential factors, universality, catharsis, the development of socializing techniques, altruism, instillation of hope, imparting of information, the corrective recapitulation of the primary family group, and imitative behavior (Yalom, 1975).

A total of six groups were formed, with three alcohol groups and three neurotic groups. The latter served as comparisons. The investigators found subjects through referrals from mental health and alcoholism agencies (including AA chapters), but did not form different groups at the same time. Once the initial group for each treatment condition had established some stability (approximately 9 months), they formed a second group. A third group was formed 6 months following the formation of the second group. The researchers charged the alcoholics no fees and all groups met weekly for a 90-minute session. The original intent was to work only with abstinent patients in the alcoholic groups; but due to lack of adequate referrals, both abstinent and actively drinking patients were accepted.

In pregroup interviews, researchers oriented the patients by exploring other personal changes patients hoped to

accomplish besides reducing their drinking. Patients' reluctance to acknowledge other areas they wanted to address was an exclusionary criterion.

Nineteen men and 13 women participated in the alcohol study groups. They ranged in age from 29 to 63, with most being in the 35 to 50 range. Seventeen were married, 11 divorced, 2 widowed, and 2 unmarried; ten reported significant marital problems and 3 separated during therapy. This data for the neurotic groups were not provided.

Since the focus of the alcohol group was the examination of relationships, outside supports (including Antabuse and AA) were also incorporated. Antabuse is a medication which, when combined with alcohol, leads to physical illness. Four patients were taking Antabuse at the time the group started and four others began taking it during the course of treatment. Seventeen members were already AA participants and continued to attend during the course of group. Thirty of the 32 members had some contact with AA during treatment. Each of the alcohol groups was led by the same female psychologist along with one of three psychiatrically trained male cotherapists. Sessions were videotaped (with segments sometimes played back in later sessions), and written summaries of each session were sent to all members.

Outcome data were collected from the patients' completion of the Hopkins Symptom Check List, from the therapists' ratings on the same instrument's global rating of change, and from independent ratings of three videotaped individual interviews at 0, 8, and 12 months. These data were compared with the outcome data of the three general neurotic groups

which included 20 participants.

Brown and Yalom (1977) reported that 4 of the 32 members dropped-out after attending only a few sessions. Two of these four members were drinking heavily at the time of their initial interview and only attended one session. The other two were abstinent but focused on their abstinence as a defense from vulnerability during group sessions. Brown and Yalom also reported that four other members dropped out during the first 6 months of the study. The researchers presented two key reasons for these drop outs: fear of intimacy with the other group members and therapists, and fear that therapy would threaten a vital long-term personal relationship.

Some general results were given in this case study report. Additional results were reported more fully in the next study reviewed (Yalom, Bloch, Bond, Zimmerman, & Qualls, 1978). The general results showed that more alcoholics (30%) tended to drop out of therapy as compared to neurotics (12%) within the first 8 months of therapy. However, once committed, alcoholics (65%) had a greater tendency to participate at least 12 months than did neurotics (47%). The Hopkins Symptom Checklist scores indicated that a majority of patients in both conditions (90% of those in therapy at least 8 months) experienced slight to marked improvement in idiographic problems, with approximately 50% moderately to markedly improved. There were no significant differences in improvement between the alcoholics and neurotics.

In discussion of these case studies, Brown and Yalom (1977) reported important factors which appeared in what the authors term the First Stage and in the Working Phase of the

group's development. In the First Stage, the member's fear of drinking must be addressed early to establish honest communication and to begin fostering trust within the group. Additionally, they found that abstinent members protected drinking members from anything that might have caused discomfort (leading them to drink) and focused on support and encouraging abstinence. Avoidance of discussing anything that may have made others uncomfortable seemed to thwart the efforts of the group. The researchers emphasized the need for each member to be responsible for him- or herself and thus free the group to address difficult but necessary issues.

Brown and Yalom (1977) identified important factors to address during the Working Phase of treatment. These therapeutic factors were: concurrent participation in support groups outside the therapy group (AA), the patient's perspective on time, the significance of alcohol and its use by individuals and the group as a whole; and factors such as dependency, rigidity and denial, responsibility, anger, depression, and sexuality.

The first factor was the encouragement of concurrent participation in AA. The differences and similarities of AA and group were identified. AA was identified as supportive of abstinence. Group was identified as intense and honest self-reflection. Both hold personal autonomy as the goal. Once this was established and discussed, the perception of dual participation in AA was transformed from "competitive with" to "complimenting" group psychotherapy.

The patients' perspective on time was also identified as a therapeutic factor. Extreme fluctuations of mood were common

among members over time. The researchers noted the importance of not getting caught up in the cycles of improvement and regression common in alcohol recovery. Even highly successful patients demonstrated progressive recovery rather than sudden therapeutic breakthrough.

The significance of alcohol, another therapeutic factor, was a theme in the groups in multiple ways. First, since members had joined a group for alcoholics, it initially served as a unifying factor. The researchers reported that it is the task of the therapist to diminish this type of bond as other sources of cohesion develop. Second, focus on their fear of drinking became a defensive function for several abstinent patients, causing them to appear cooperative but avoid deeper personal issues or anxiety-provoking elements of the here-and-now experience.

Dependency was another factor the researchers identified. It appeared particularly around the time members gave up alcohol. Two types of dependency were recognized: (a) a direct, overt expression of dependency associated with unrealistic expectations, and (b) a less overt expression of dependency. Anticipation that members would experience a "void" after becoming abstinent was identified as an important factor. Establishing the availability of a substitute for patients' dependence on alcohol (e.g., additional contact with members, therapists between group meetings, or both; AA participation) was critical both in times of crisis and throughout the life of the group. Additionally, it was recognized as important that members be assured that the group was ongoing and would meet at the appointed hour. These

efforts, said the researchers, contribute to the development of trust in the therapeutic encounter.

Within the overt type of dependency expression was the development of "the sick role" as a patient's identity. While it served to establish a position in the group, it undermined self-esteem. Conversely, counterdependent behaviors (e.g., "tough guy" posturing, feelings of omnipotence, and grandiosity) were reported as the primary means of dealing with dependency for many members. These behaviors were often identified by other patients as "successes", but were anxiety-provoking for the successful individuals. For many, success brought the threat of envy by others or the threat of losing the support of the group and the therapists. The researchers noted the importance of creating relationships within the group in which patients feel they would not be abandoned whether they felt badly or demonstrated improvement.

An experience described by researchers was the patients' "hitting bottom" sometime prior to, or during the course of group. According to Brown and Yalom (1977), this can be an invaluable reference point from which patients may make shifts in their life perspective. However, they may also emerge from that experience fearful of its extreme nature. As a result, they may seal off that experience and appear rigid or form a posture of denial. Addressing this rigidity and denial is another therapeutic factor. The researchers believe that in order for the therapist to help patients maintain "hitting bottom" as an integrative experience, the therapist must repeatedly approach patients without fear and gently lead them back to their hitting bottom experience.

Guilt, blame, and responsibility were also identified as therapeutic factors which need to be addressed. The researchers identified patients as quick to assume blame and guilt for dysphoric events in the group or distress suffered by others. These patients carried a deep sense of responsibility for others and avoided any behavior which might cause pain, often at the expense of dealing with their own feelings.

The researchers also pointed out the absolute necessity to establish a norm that anger and its expression was not only acceptable in group, but that it was essential for the group to work effectively. The difficulty they found was in moderating the expression of anger so that members would not become overwhelmed with anxiety and guilt. Another therapeutic factor, then, is to help patients recognize their anger and manage their expression of it. Additionally, it is important that therapists model appropriate expression of anger and a nondefensive acceptance of others' anger. The importance of valuing and receiving such expressions of anger and discussing, where appropriate, the accuracy of the member's perceptions was stressed.

Sexuality is also a therapeutic factor. The researchers noted the alcoholics' greater resistance to discussing issues of sexuality in group as compared to general neurotics. Many of the alcoholics denied their sexuality out of fear that, should they begin to express their sexuality, they would lose control. Therapists, they stated, must actively confront the topic and repeatedly prod the group to disclose sexual anxieties, attitudes, feelings and fantasies.

The final factor identified by the researchers as important to address is that of depression. As alluded to previously, in relation to the issue of dependence, a sense of depression often accompanies the loss of alcohol at the point one achieves abstinence. At that point, the researchers found that members needed a great deal of support. Brown and Yalom (1977) indicated that therapists need to learn to titrate the support of the group. They must help patients deal with despair and yet not rush in to steal their experience of grief.

Concern about the validity of this research arises from its presentation as a case study. Specifics of treatment and statistical results are reported in Yalom et al. (1978). Also of concern for this study is its low statistical power. The small number of subjects in the groups and subgroups leads to reservations regarding the sensitivity of the study and the reliability of its conclusions. Additionally, there is concern that only one of the co-therapists worked with all three groups, questioning the consistency of the treatment across groups.

Concurrent participation in AA meetings was encouraged as a support to the members through particularly stressful periods during the course of group therapy. The researchers also mentioned that at times concurrent membership in AA and the group was used by members as a resistance to explore intense interpersonal issues. However, the members' attendance at AA meetings was not held constant, and the degree to which AA contributed to the therapeutic effort was not identified. The lack of investigation into the interaction of these

different treatments threatens the construct validity. It should also be noted that the members were volunteers who chose this type of intense interpersonal group experience. Generalization beyond this type of participant is discouraged.

Yalom, Bloch, Bond, Zimmerman, and Qualls (1978) published additional results and information regarding the differences in treatment conditions of the same six therapy groups. The alcoholic groups were funded by a research grant and no fees were charged. However, the neurotics were charged according to the sliding-scale ($2-$15 per session) used in the Stanford University Department of Psychiatry's Outpatient Clinic, the location where the study groups were conducted.

There were three sources of outcome measures: patients, therapists, and independent judges. Patients were interviewed by the same researcher three times: before onset of therapy, at 8 months, and at 12 months. Patients constructed a list of problems for which they had entered therapy and rated each on a nine-point distress scale. They also developed an associated goal for each problem. At subsequent interviews patients rated their problems on the distress scale, and on a 9-point scale that reflected the extent to which they thought they had achieved their goal with respect to the specified problem.

The patients also completed three global scales reflecting the degree of change they believed they had accomplished, the extent to which their complaints had changed over the year, and their overall satisfaction with the results of therapy. Additionally, before therapy and at 12 months, patients completed a Hopkins Symptom Checklist which was modified to increase its relevance to the clinical population.

However, the researchers did not identify how it was modified.

The Curative Factor Questionnaire (Lieberman, Yalom, & Miles, 1973) contains 19 factors that are effective mechanisms of change in group therapy. It was administered to both groups at 8 and 12 months after therapy began to determine if patients perceived the therapy groups as receiving equivalent therapy. The items include such factors as feedback, catharsis, self-disclosure, acceptance by others, altruism, direct advice, different types of insight, universality, and existential factors. Different types of therapy groups accent different factors, and even within one group, individuals may select various change pathways through the therapeutic process. T tests indicated that there were no differences on any of the 19 items between alcoholic and neurotic groups, meaning patients perceived that the groups offered similar types of therapy.

At the onset of therapy, the therapists listed the patients' major problems and formulated a therapeutic goal for each problem. Eight and 12 months later, therapists rated each problem. At the end of 12 months, they also rated each patient on a 9-point global measure of change scale, ranging from 1 (worst possible outcome) through 5 (unchanged) to 9 (best possible outcome).

The interviews mentioned above were observed by teams of three independent judges from Stanford's Department of Psychiatry clinical faculty. After viewing the before-therapy tape, each of the three judges developed a list of the patient's problems. The three problem lists were written out on a blackboard and consolidated by the judges. The team then

developed a goal for each problem. The tapes of the 8- and 12-month interviews were watched and, using the goal as a standard, rated by each judge according to the degree of change for each problem. The judges also rated the overall outcome of the patient on a different 17-point global improvement scale ranging from 1 (worst possible outcome) through 9 (unchanged) to 17 (best possible outcome).

T tests were performed to compare severity of psychopathology between groups using data collected from the Hopkins Symptom Checklist. There were no significant differences between the alcoholic and neurotic patients in initial levels of psychopathology except for the category of alcohol and drug dependence. The major problems listed before therapy by the 29 patients who continued in therapy at least 8 months were sorted into 12 categories. No significant differences existed between conditions or alcohol groups with regard to types of problems. The mean level of distress for all categories was 6.36 for alcoholics and 6.65 for neurotics.

The problem lists constructed by the judges and by the the therapists prior to the onset of therapy were also categorized. The only consistent difference between groups was in the category of dependency, with the alcoholics more often deemed pathologically dependent. The therapists' and judges' pretherapy severity ratings for all problems showed no significant differences between the alcoholic and neurotic groups.

Ratings were examined 8 months after treatment. T tests were performed to assess significant differences on achievement and global ratings from the three sources

(patients, therapists, and independent judges). In the same manner, reduction in distress for each sample was examined by assessing pretherapy and posttherapy differences on the target problems and on the Hopkins Symptom Checklist.

The alcoholics were found to be older, with a mean age of 41 years (range 29-55 years) when compared to the neurotics, whose mean was 28 (range 21-44 years). The alcoholics were also more likely to be married (75%) than neurotics (18%). Analyses indicated that both samples experienced considerable achievement of goals as a result of 8 and 12 months of group therapy, with no significant differences in improvement between the alcoholic and the neurotic samples ($p < .05$). Additionally, both samples indicated a reduction in distress over problems at both the 8 and 12 month follow-ups ($p < 0.01$).

As reported in Brown and Yalom (1977), alcoholics showed a greater tendency to drop out of therapy in the first few meetings, but once alcoholics completed the first meetings, more of them remained in therapy for the full 12 months. However, it was reported in this study (Yalom et al., 1978), that a number of the neurotics dropped out due to logistical reasons related to professional or family situations. It would be interesting to compare the durations of therapy participation of the two groups excluding the neurotics who dropped out because of these professional or family situations.

From these results the investigators concluded that outpatients with drinking problems can be successfully treated in long-term interactional group psychotherapy. However, they

also noted some aspects of the treatment which limit the generalizability of these findings to the type of therapy performed in this study. The therapy was carefully modulated with the use of written summaries to maintain anxiety levels below that which would lead to acting out (drinking). The written summaries consisted of descriptions of meetings and editorial notes by the therapist (e.g., process observations made in group, reinforcement of certain behaviors, new interpretations). The researchers speculated that these written summaries promoted cohesiveness, bridged the gap between meetings, and decreased anxiety by helping members assume a self-reflective posture. A confounding variable was that written summaries were used only with the alcoholic groups and not with the neurotic groups. Another concern regarding the reliability of treatment implementation was the absence of information on the therapists for the neurotic groups. It was implied that no one therapist functioned in all three groups. This was in contrast to the alcoholic groups, which had the same female psychologist with varying cotherapists. As in the Brown and Yalom (1977) case study, there are several threats to the validity of this empirical study: low statistical power, possible application of treatment through a variety of providers, and inadequately assessed concurrent participation in AA meetings.

These studies indicated that interactional group therapy with volunteer alcoholic patients can be as effective as group therapy with neurotics. The researches also identified the following themes as important: dual membership with outside support, time perspective, the significance of alcohol and its

use, dependency, fear of success, denial, and rigidity, responsibility, anger, depression, and sexuality. The use of written summaries was also identified as an important therapeutic factor to contain intense affect between sessions and to foster group cohesion and growth.

Special Population Treatment

Ranganathan (1994) evaluated rural camps which treat alcoholism throughout the Tamil Nadu region of India. He found unusually high recovery rates following therapeutic intervention when compared with urban treatment programs in India. The camps operate programs which involve 3 days of detoxification by medical personnel with the involvement of the local doctor. Following detoxification, there is a structured program which runs for 12 days and utilizes group therapy with individual counseling sessions. Family and community relations are also included in the program.

The group therapy evaluated in this study involved groups of 8 or 9 members with the same counselor for 12 days. Staff members usually spent 12 hours per day with the patients. Group therapy involved sharing by members with a focus on communication. Topics included worst drinking episodes, incidences of blackouts, loss of control, unsuccessful attempts to give up alcohol, damage related to job or family, and feelings of guilt and shame. The investigator suggested that this sharing helped members understand their powerlessness over alcohol, deal with their shame and guilt, socialize and experience the benefits of fellowship, and learn new methods to maintain sobriety.

Information regarding the extent and consequences of the

patient's abuse of alcohol, and their current social, family, financial and occupational status was gathered during individual counseling sessions. These sessions were also used to identify the individual's short- and long-term goals for recovery. Family members participated in a limited, structured program which provided information about alcoholism. Support people, identified as people who had a keen interest in the patient from within the community (e.g., employers, village leaders, aunts, uncles, friends), were also involved in the recovery. They were given a 2-hour presentation on the treatment program. Antabuse was administered through camp and local doctors as an adjunct treatment for 1 year beyond the camp experience. Additionally, patients returned to the camp once a month for follow-up sessions with their individual counselor.

Between 1989 and 1992, 105 patients were treated at four camps. The mean age was 40 years with a range between 24 and 62. The patients were 94% Hindu, 3% Christians, and 3% Muslim. They were also 94% married. The average length of time participants had been drinking was just over 5 years. Also, 31% had one close member of the family with the problem of alcoholism and 13% had either a father or brother who died of an alcohol-related illness. Patients were followed for a period of 1 year with 87 of 105 (83%) remaining sober.

Ranganathan (1994) identified five indirect factors which were believed to be influential on the group therapy program used at the camps. First, the closely knit local community allowed the large population of recovering alcoholics a great deal of visibility which created a multiplying effect. Second,

the camps were in a strong agricultural area of India that provided ample employment opportunities for recovering addicts returning to the work force. Third, the managers and teachers were highly respected; thus, the program was held in high regard and well utilized by the community. Fourth, the general ambiance of the region was one of trust in God, which appeared to play a subtle but inspiring role in leading patients toward recovery. And fifth, the motivation to take Antabuse regularly for 1 year post-camp experience was high.

Clearly this rural camp experience for alcohol recovery appears successful. Although these environmental factors appear at face value to contribute to the patients' recovery, no statistical analysis was done to determine the extent to which group therapy, individual counseling, support network's involvement, Antabuse or follow-up sessions contributed to the high rate of sobriety following 1 year of recovery. A more sophisticated study of these factors is necessary before generalizations can be made. Additionally, cultural differences should be assessed prior to generalization to other cultures.

Group-based programs in rural areas may be quite effective. Specifically, groups which encourage communication and the development of social and relapse prevention skills appear to be highly successful. Other factors that may contribute to effective treatment are the high value placed on recovery by the community, high utilization of the treatment program, ample employment opportunities, and a strong ambiance of spirituality. Fostering and developing these attributes in future clinical treatment programs is recommended.

Patients' Attribution of Change

Lovett and Lovett (1991) examined 70 consecutively admitted alcohol patients at an inpatient alcohol and addictions treatment hospital in Chester, England. The aims of their study were: (a) to identify therapeutic factors perceived as helpful by patients, (b) to determine whether patients' rankings of therapeutic factors changed according to type of program, (c) to assess whether patients' rankings of factors changed according to length of time spent in groups, and (d) to identify therapeutic factors perceived as helpful by therapists.

The treatment involved an introductory program followed by a treatment program. The introductory program lasted 2 weeks and consisted primarily of medical detoxification and cognitive-behavioral group intervention with three sessions at AA, two occupational therapy sessions, and one anxiety management session. The treatment program involved group therapy which focused on interpersonal feedback concerning "here-and-now" behavior as well as a group addressing future plans and one focussing on weekend planning. Patients participated in the treatment program for up to 6 weeks before they were discharged.

The patients were administered an adapted form of Yalom's therapeutic factor questionnaire (Yalom, 1975). However, the researchers did not identify how the questionnaire was adapted. Yalom's questionnaire includes 12 therapeutic factors: Altruism, Cohesiveness, Universality, Interpersonal Learning-input (patient learns from others' perceptions of him or herself), Interpersonal Learning-output (interpersonal

experimentation), Guidance, Catharsis, Identification, Family Reenactment, Self-understanding, Instillation of Hope, and Existential Issues.

Sixty-four patients (31 women and 33 men) completed 76 questionnaires. Respondents ranged in age from 25 to 63 years old ($\underline{m}$ = 43). Thirty-four patients completed the questionnaire at the end of the introductory program, with 12 taking the questionnaire again at various times during treatment: at either 2 weeks into their treatment program ($\underline{n}$ = 12), 4 weeks into their treatment program ($\underline{n}$ = 26), or at their discharge ($\underline{n}$ = 4). The 14 therapists also completed the questionnaire, although the researchers did not say at what point in treatment.

All patient ratings for the 12 treatment factors (both the introductory group and the pooled scores from the entire treatment group) were correlated using the Spearman correlation coefficient. The results were significantly correlated ($\underline{r}_s$ = .98). Internal agreement among members of the introductory group was significant according to Kendall's coefficient of concordance ($\underline{W}$ = .31, $\underline{p}$ < .05). The same Kendall's coefficient was used and similar significance was found among those completing the questionnaire during the treatment program ($\underline{W}$ = .37, $\underline{p}$ < .05). Internal agreement of ranking for all respondents, independent of their treatment (cognitive-behavioral or here-and-now), was significant ($\underline{W}$ = .42, $\underline{p}$ < .05). Factors perceived as most helpful were self-understanding, existential issues, and cohesiveness. Identification, guidance, family reenactment, and instillation of hope were regarded as least helpful. This pattern of

ranking was replicated by the subgroup which completed the questionnaire twice.

The therapists agreed with patients' ranking of therapeutic factors, but the correlation coefficient was not as high (r_s = .62). Similar to the patients, therapists considered cohesiveness and self-understanding most helpful; identification and guidance were seen as least helpful. However, therapists ranked existential issues quite low (9th), whereas patients in the subgroups ranked it 1st or 2nd. The internal agreement for the entire therapist population was significant (W = .44, $p < .05$).

Reliability of treatment implementation can be questioned due to the lack of information regarding the therapists involved. The number of therapists involved in the different types of treatment was not reported, nor was therapists' participation in both types of treatment clarified. Some concerns about this study's construct validity exist. The researchers did not describe to what extent the therapeutic factors were defined to the patients. Neither was it clear whether patients were instructed to evaluate therapeutic factors of the group therapy only, or of the entire inpatient milieu.

Generalization should be tentative since the demographic variables of the patients, although reportedly gathered as part of the questionnaire, were not discussed. The heterogeneity of respondents should not be assumed without supporting data and generalization should be limited to patients on similar inpatient units.

In summary, patients indicated self-understanding,

existential issues and cohesiveness were the most important therapeutic factors in both cognitive-behavioral and here-and-now group therapy. Identification, guidance, family reenactment, and instillation of hope were identified as the least helpful therapeutic factors. Therapists identified cohesiveness, self-understanding and existential as important factors, but rated existential as a much lower factor than did patients.

Advice or Extended Treatment

Chick, Ritson, Connaughton, Stewart, and Chick (1988) conducted a study examining outcome differences between patients given short messages of advice at the time of their interview, extended messages of advice at the time of their interview, or extended group therapy.

Over a 12-month period, every other patient who came into the only alcohol treatment clinic in Edinburgh, United Kingdom, was approached and invited to participate in the study. Patients were asked to identify a close friend or relative with whom the staff could communicate regarding the patient's recovery and well-being and if they would return for a 2-year follow-up interview. The completed interviews (N = 152) were placed into anonymous packets and grouped according to their marital status and severity of alcohol dependence. From these groups, patients were assigned to the simple advice (n = 41), amplified advice (n = 55) and extended treatment (n = 58) conditions.

Patients were followed up at 3-month intervals for 2 years beyond treatment. Follow-up included a clinical interview which was conducted by a social worker. Follow-up

also included the completion of the Scale of Alcohol-related Problems, developed by Edwards, Orford, and Egert (1977), which provides a measure of alcohol-related physical and mental symptoms, and a measure of alcohol-related social problems. The scale was partially completed by the patient and partially completed by the previously identified relative or friend of the patient. The follow-up also included patient-reported estimates of alcohol consumption in both the past month, and in the past year.

The simple advice involved telling patients, "You have an alcohol problem. The only treatment is to stop drinking." It emphasized that the responsibility lay in the patient's hands. Communication was limited to 5 minutes.

The patients in the amplified advice condition received the same message but the psychiatrist was allowed 30-60 minutes to enhance the patient's motivation by encouraging the patient to reflect on the reasons why radical change was necessary and discuss how it may happen. For married couples advice was sometimes given on how the cohesiveness of the marriage could be improved.

Extended treatment consisted of the simple advice condition described above and an offer to participate in the inpatient or day hospital group therapy programs. These programs were cognitive in style, and focused on maintaining sobriety by educating patients about alcohol problems, social skills, and relapse prevention. Reducing denial and rationalization by patients was also a focus.

Eighty percent of those approached agreed to participate. When compared with the patients who were not invited to

participate (control group) the treatment sample included fewer socially isolated individuals (two-thirds of the sample were married or cohabitating compared to half of the control group patients) and fewer women (1 in 5 as opposed to 1 in 4 control group patients). Of the 58 patients offered extended care, 56 attended at least one additional outpatient session, and 32 (55%) attended at least 10 appointments. Thirty-two (55%) had previous inpatient treatment; 7 (12%) had one or more readmissions. Average time in the extended treatment was 19 days.

Abstention or drinking without any problems for the full year or more prior to the follow-up was as frequent in the two advice groups as it was in the extended treatment group. However, extended treatment was significantly better than either of the advice groups in enabling patients to maintain abstinence or trouble-free drinking for a minimum of 1 month. Using chi-square with Yates correction, the extended treatment patients were found to have significantly fewer continuing problems compared to the advice patients ($p < .05$). In order to control for skewed distribution of problem scores at intake, a Mann Whitney U test was performed comparing the groups on the difference between intake and follow-up problem scores. The extended advice group had significantly fewer problems ($p < .05$) than the other two groups. The number of abstinent days in the month prior to follow-up was also significantly different for the treatment groups ($p < .05$). An analysis of covariance confirmed a significantly greater decrease in the problem score of the extended treatment group when controlling for abstinence ($p < .009$).

Patients who were offered extended treatment tended to improve more on all measures than either of the advice groups, though there were few differences between groups in alcohol-related physical symptoms, trouble at work, or trouble with the law. The extended treatment patients' behavior in their families improved significantly. Improvement occurred in terms of an increase in joining family activities ($p < .027$) and decreases in threatening violence ($p < .009$), breaking or damaging things ($p < .03$), jealousy and possessiveness ($p < 0.03$), causing fear and anxiety in children ($p < .03$), and being noisy and disruptive at night ($p < .07$). Commensurate with this, there was a significantly higher trend for marriages to stay together in the extended therapy group than the two advice groups ($p < .02$). Extended treatment patients also showed a lower rate of alcohol consumption than the advice groups, but this difference was not statistically significant.

Although some interesting results were obtained, little can be generalized from this research regarding therapeutic factors. It can be said that educative cognitive therapy with a focus on abstinence, social skills, and relapse prevention training appears to decrease alcohol-related behavior problems with couples and within the family. However, without evaluation of cultural issues, generalizability appears limited to patients in similar programs within the United Kingdom. More sophisticated statistical analysis with examination of the elements of group therapy which contributed to the therapeutic gains would be beneficial.

In summary, this study has identified the therapeutic

factors of alcohol education, social skills training, and relapse prevention training as helpful in extended cognitively-oriented group therapy. Interventions aimed at decreasing denial and rationalization were also found to be beneficial. Advice giving was not found to be as beneficial in decreasing behavior problems in couples and families, but appeared helpful in terms of maintaining abstinence.

Patients' Personal Construct Changes

Heather, Edwards, and Hore (1975) examined patients' understanding of their alcohol problem before and after participating in an inpatient group therapy treatment program in Manchester, England. Group therapy was the principal technique used in a 10- to 12-week inpatient program on the alcoholism unit. Meetings, held every morning for 2 hours, were led by various staff members, including the nursing staff. Patients did not leave the unit except for planned group activities, and they did not go home for visits. The focus of the group was on the here-and-now, with little attempt to discover the reasons behind drinking. Group identification and dependence on the group was strongly emphasized. Dependence and identification were encouraged beyond the time of discharge through follow-up meetings and other social events. The aim of the program, as described by the researchers, was the exchange of dependence on alcohol for dependence on the group.

The repertory grid technique was used to calculate movement between poles of bipolar personal constructs. Ten constructs were investigated, with 5 representing aspects of self-construction and 5 representing drinking roles. These

personal constructs were described as: (a) myself as I would like to be (ideal self), (b) myself as I will probably become (future self), (c) myself as others see me (social self), (d) myself as I used to be (past self), and (e) myself as I am (actual self); with drinking roles described as (f) a typical alcoholic such as one might find on this unit (typical alcoholic), (g) an average social drinker (average drinker), (h) a recovered alcoholic (recovered alcoholic), (i) a teetotaler (teetotaler), and (j) an alcoholic who does not benefit from treatment (nonbenefiting alcoholic).

After detoxification, and again at the time of discharge, patients were shown ten standard pairs of constructs and asked to name an important difference based on their own character, personality or emotional state. For example, the first pair presented was ideal self and actual self. One 19 year old woman responded that her ideal self "enjoys life" while her actual self "does not". The patients were then asked to rate each element for each construct on a 7-point scale, developing a repertory grid. Shortly before discharge, patients completed another grid. The grid was analyzed by Slater's Ingrid Programme (Slater, 1967) to determine distances of movements along the construct poles. Finally, a factor analysis of these distances was performed.

Forty successive admissions (32 men and 8 women) who completed the program were examined and found to resemble typical patients attending alcoholism units in England and Wales as identified by the third researcher in unpublished research. Patients ranged in age from 18 to 63 years old ($\underline{M}$ = 39.9). Average length of stay was 9 weeks (range 4-21).

Patients were described as nonpsychopathic and socially stable. Nonpsychopathic meant that they did not have any history of behavioral disturbance or evidence of gross maladjustment as a child, were not frequently aggressive, were able to form permanent relationships, and were able to defer gratification. The rating of social stability was not defined.

Analyses indicated that the pattern of change occurring during group therapy was similar across patients ($p < .001$). However, this conclusion cannot be attributed to group therapy due to inadequate controls. Despite this weakness, conclusions could be drawn because the aim of the study was to describe psychological changes and relate them to outcome. First, consistent change in constructs did take place during group therapy. Some components of this change seem to have predictive implications for outcome of treatment. The actual self (the way the patient construes him/herself) showed the largest and most consistent changes relative to other elements, followed by the social self (the way he/she construes others' constructions of him/herself). These changes have face validity in terms of movement away from socially-disapproved roles toward more socially-approved roles. Secondly, all the changes involved at least one change in the element of self construct. There was no significant change in personal constructs of drinking roles. This suggests that changes in drinking-role elements are smaller and less consistent than changes involving aspects of self.

Regarding outcome, the patients that did well were those who distinguished less between different types of alcoholics (e.g., typical alcoholic, nonbenefiting alcoholic). Successful

patients also saw alcoholics as a distinct class of drinker.

Large changes in constructs of self, previously defined as movement toward respectability and self-esteem, had no apparent relation to the success of therapy. In fact, improved self respect was highly associated with relapse. The researchers believe that this is an indication of overconfidence on the patients' part to "conquer their problem" (Heather, 1975, p.1249). At the other extreme, patients who moved away from self-respect also had high rates of relapse. The patients most unlikely to relapse were "marginal deviants," in the sense that they saw themselves as excluded from the conventional world and from the deviant alcoholic subculture. An important treatment factor inferred from these findings is that the identification and reduction of such isolation experienced by patients may decrease the rate of relapse.

This research had no stated hypothesis to be tested. Rather, it was presented as an experimental examination designed to "open-up" the area of study in question in hopes that fruitful hypotheses would emerge. Accordingly, generalizations or firm conclusions of causation would be highly inappropriate.

In terms of clinical application, it seems that large self-construct changes in here-and-now group therapy may indicate overconfidence and predict relapse. Similarly, large decreases in self-esteem may also lead to relapse. Nonrelapsing patients apparently viewed alcoholics as similar to each other and viewed themselves as isolated from both the alcoholic subculture and from the general culture as well. The

identification of and intervention within the isolation experience appears to be a therapeutic factor worth pursuing.

Aftercare Treatment Factors

A large body of research exists which describes the importance of maintaining therapeutic gains established during treatment. However, few studies examined the therapeutic factors which contribute to these gains. This section reviews research which evaluated the therapeutic factors involved in the transition from primary intervention groups to aftercare groups. Research which evaluated the therapeutic factor of treatment matching in aftercare is also reviewed.

Transition to Aftercare

People who are socially isolated, lower in socioeconomic status, or have severe symptoms of substance abuse are least likely to complete referral from inpatient treatment programs to outpatient programs. These individuals drop out rapidly once they make contact with the outpatient clinic and tend to experience less benefit from aftercare treatment (Fagan & Mauss, 1986; Institute of Medicine, 1990; Littrell, 1991; Waisberg, 1990). The problem of high drop-out rates is made more significant by findings which demonstrate that aftercare involvement is associated with positive recovery outcomes (Costello, 1980; Ito & Donovan, 1990; Moos, Finney, & Cronkite, 1990).

Hanson, Foreman, Tomlin, and Bright (1994) investigated the effect of modifying a substance abuse treatment program to include experiential, educational, and supportive transition

groups as a final component of treatment. The program served inner-city residents who were primarily unmarried, unemployed African American and Hispanic men. Transition group goals were as follows: (a) to sensitize patients to their need for ongoing treatment, (b) to acquaint them with the setting and services of the outpatient clinic to which they were being referred, and (c) to provide them with support as they made the transition to outpatient care. The researchers hypothesized that improving the transition from the inpatient ward to an outpatient alcoholism clinic would lead to reduced relapse and aftercare drop out.

Group therapy included didactic presentations regarding clinic services, procedures, and location; as well as discussions about difficult situations that put members at risk for relapse. Members' ambivalence and anxiety about remaining sober, and the costs and benefits of sobriety were also addressed. The group experience also included discussion about alternative responses for handling high-risk situations, self-motivational statements regarding the need to continue treatment, and resources to support their sobriety efforts. The groups, which were approximately half experiential and half didactic, used the patients' experiences as a basis for interaction.

Information was gathered from inpatient records about the patients' demographic characteristics, their alcohol and illicit drug use, and their past treatment experiences. From the outpatient clinic's records, information was collected about the patients' contacts with the clinic, lengths of stay, compliance with treatment, and patterns of alcohol and illicit

drug use. To evaluate the effect of transition groups on aftercare treatment outcome, the attendance of patients referred to the outpatient clinic during the 16 months prior to implementation of the transition group (period 1) was compared to that of patients referred during the 12 months following implementation. Statistical analyses used were: correlations, ANOVAs, t tests, and chi-square tests.

Analyses showed no significant differences in demographic characteristics between the two treatment conditions. Each group had similar drinking histories and problems associated with drinking. The percentage of patients who made contact with the outpatient clinic was also similar between conditions. However, once contact was made with the outpatient clinic, patients who participated in the transition group had significantly longer lengths of stay (20.4 weeks) compared to those who did not participate (16.7 weeks; $p < .05$). In addition, transition group patients were more likely to comply with treatment and to establish sobriety in the first month following contact than patients who made contact prior to the implementation of the transition group. Level of compliance was measured by number of appointments attended, number of extended absences, and degree of problem focus in treatment. Also, the transition group patients were more apt to establish sobriety in the first month following contact (73.5%) compared to those who did not participate in the transition group (51.7%).

Further analyses identified two client characteristics at initial admission which correlated with attendance outcomes. Older patients and patients who had contact with the

outpatient clinic prior to their admission were more likely to complete the referral to the clinic than younger patients and patients with no previous clinic contact. Analyses were repeated controlling for age and number of admissions to the inpatient ward. Regardless of the number of their admissions, a greater proportion of patients referred during the transition group condition were compliant with their treatment. Readmitted patients who were referred to the outpatient clinic during the transition group were significantly more likely to make clinic contact and establish their sobriety than readmitted patients referred before the start of the transition group.

The researchers concluded that participation in such transition group therapy was associated with beneficial treatment outcomes, especially for clients who had experience in an alcoholism clinic prior to their hospitalizations. This conclusion suggests that people who have had prior, unsuccessful experiences in an outpatient clinic will profit from interventions designed to prepare them more fully for outpatient care.

The researchers stated that caution should be used in interpreting the results of this study because it examined two groups over different time periods. In addition, the researchers did not state whether or not other treatment or setting changes occurred during the study. These research designs could be improved by randomly assigning patients to the treatment conditions and evaluating treatment outcomes during the same time period. Additionally, it would be helpful to replicate these findings with more heterogeneous

respondents based on ethnicity, socioeconomic status, and marital status.

Panepinto, Galanter, Bender, and Strochlic (1980) investigated the effect of educational/experiential group therapy as a transition from an inpatient detoxification unit to an outpatient clinic. The treatment center was a division of the Department of Psychiatry of the Bronx Municipal Hospital Center. All patients admitted to the inpatient treatment unit between February 1 and July 31, 1977, were included in the comparison group. The experimental group included all patients admitted to the inpatient unit during the same months the following year who were referred to the outpatient clinic via transition group therapy.

The transition group met for ten 90-minute sessions in the outpatient clinic. Sessions were both educational and supportive/experiential. Inpatients were escorted to the outpatient clinic and wore street clothes to encourage interaction with outpatients. In all sessions therapists emphasized that alcoholics need to continue outpatient treatment in order to remain abstinent and permanently change their lifestyle. The group, offered in Spanish as well as English, was mandatory for all inpatients who received medical clearance. It was also open to all patients recently discharged from the inpatient unit. Outpatients were encouraged to share with the inpatients their successes and difficulties in the transitions to abstinence and to life in the community.

The patient population was approximately 35% Black, 35% Hispanic, and 30% White. The majority of the patients were men

(75%). They were in the following age categories: 45 and older (25%), 30 to 45 (55%), and under 30 (20%). Approximately 40% were married, 90% had permanent living arrangements, and 45% were employed or participating in a training program.

Seventy-one percent of the inpatients who participated in the transition group therapy returned to the outpatient clinic, while only 53% of those in the control treatment condition returned to the clinic ($p < .001$). When the researchers examined the results by age group, patients under 44 showed significantly greater attendance in aftercare treatment following the transition group therapy condition ($p < .05$) than those in the comparison group. Results also showed higher aftercare attendance by patients for whom this was their first admission to an inpatient detoxification unit ($p < .01$) than readmitted patients.

Many more Black and Hispanic patients in the experimental group returned to the clinic as compared to those in the comparison group. White patients, however, showed no significant difference in attendance when the two treatment conditions were compared. The researchers hypothesized that support and acceptance within the groups were key elements in the effect of the transition group. Since the population was 70% nonwhite, a sense of support and affiliation among white patients may have been diluted.

Similar to the previous study, this study was exploratory and descriptive in nature. It examined the impact of two treatment conditions during different times. It would be beneficial to replicate this study with more random assignment to conditions and with a more heterogeneous sample. The

researchers did comment on the difference of experiences between ethnicities, but they did not examine the effect of socioeconomic status or stability of living arrangements on treatment outcomes. Ninety percent of the patients in this study had stable living arrangements which is unusual for those typically seeking treatment for alcoholism. It would be interesting to conduct a similar study with a population of more transient patients.

In summary, research suggests that transition groups which address orientation to aftercare, triggers for drinking, ambivalence regarding remaining sober, costs and benefits of sobriety, alternate responses to high risk situations, and supportive resources improve patient treatment completion and compliance. Supportive experiential transition groups also appear to be helpful in improving continuity of care to the outpatient setting. Support and acceptance in the new environment were identified as key therapeutic factors in the success of transition groups.

Treatment Matching in Aftercare

Kadden, Cooney, Getter, and Litt (1989) studied 96 patients who had completed a 21-day group therapy inpatient drug and alcohol abuse treatment program and then participated in aftercare group therapy. The researchers investigated whether or not coping skills training (CST) or interactional group therapies (IGT) would be more beneficial for particular types of patients. They hypothesized that patients with less psychopathology, sociopathy, or with higher cognitive functioning would benefit more from IGT than CST because of the insight and interpersonal experiences available in the

social environment of the interactional group. Conversely, they believed that sociopathic patients, patients with strong coexistent psychopathology, and neuropsychologically-impaired patients would find the interpersonal and conceptually complex nature of interactional group therapy inhibitive and less effective in their recovery. They expected these patients would experience greater benefits from the concrete, instructional, and goal-focused coping skills group therapy.

The study sample included 66 men and 30 women. The mean age of participants was 39.1 years (SD = 13.5). Eighty-four percent met the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) criteria for alcohol dependence and 16% met it for alcohol abuse. Subjects reported an average of 45 days of heavy drinking in the 90 days prior to admission to the inpatient program.

The Psychiatric Severity subscale composite score of the Addiction Severity Index (ASI) was used to assess global psychopathology. This instrument has been shown to be reliable and valid (McLellan, Luborsky, Woody, & O'Brien, 1980) and to predict the success of substance abuse treatment (McLellan, Luborsky, Woody, & Druley, 1983). The California Psychological Inventory's Socialization Scale (CPI-So) provided a continuous measure of sociopathy (Megargee, 1972). The research compared CPI-So to other unmentioned indexes of sociopathy (also administered during intake phases). It proved to be a valid and reliable measure of this construct in these alcoholic subjects.

Neuropsychological status was rated using the Wechsler

Adult Intelligence Scale-Revised (WAIS-R), Wisconsin Card Sorting Test (Heaton, 1981), the Trail Making Test (Russell, Neuringer, & Goldstein, 1970), the Four-Word Short Term Memory Test (Ryan & Butters, 1980),and the Face-Name Paired Associates Test (Becker, Butters, Herman, & D'Angelo, 1983). A factor analysis resulted in a composite neuropsychological measure which accounted for 49% of the variance. A single neuropsychological status score was generated for each subject by weighting each of the standardized measures by its factor score coefficient and summing across measures.

The aftercare therapy involved either interactional group therapy or coping skills training, educational classes, family therapy, and AA meetings. The CST condition provided a highly structured group experience designed to foster the acquisition of problem solving, interpersonal, and relaxation skills, as well as skills for coping with negative moods and urges to drink. Members learned how to recognize and handle situations which might lead them to drink. Didactic presentations, behavioral rehearsals within group sessions, and homework exercises were used. Interactional problems among group members were not a focus of this therapy.

IGT was based on the work of Yalom as adapted for work with alcoholics (Brown & Yalom, 1977). These groups focused on interpersonal relationships and pathology as manifested in the here-and-now interactions of the group. Summaries were written by the therapists following each session and mailed to members to be read prior to the following session. Therapists avoided providing specific skill guidelines for coping with problems.

All members of both groups had a common termination date.

Aftercare treatment in both conditions consisted of 26 weekly 90-minute sessions. Five coping skills groups and five interactional groups were conducted. All therapists had a minimum of 2 years of clinical experience and were trained for participation in the study using unspecified readings of unpublished training manuals written by the researchers.

Multivariate analyses of variance (MANOVA) showed no significant pretreatment differences between CST and IGT on measures of alcohol consumption, social functioning, psychological functioning, or neuropsychological status ($p < .05$). An analysis of variance (ANOVA) on the number of sessions attended by subjects indicated no significant effect for treatment type ($p > .10$). Furthermore, the omnibus multivariate analyses found no significant differences in outcomes attributable to a specific therapist effect ($p > .10$).

ANOVA with repeated measures showed significant pre-post changes for heavy drinking, ASI Psychiatric severity, and PFI Social Behavior. Additionally, a Pearson correlation showed that the three patient characteristics (psychopathology, sociopathy, and neuropsychological status) were not closely related (sociopathy with psychopathology, $r_s = .17$; sociopathy with neurological function, $r_s = .17$; psychopathology with neurological function, $r_s = .11$).

Hierarchical linear regression analyses was used to test whether or not any of the three patient characteristics would interact with treatment type. The interaction of ASI Psychiatric Severity with treatment type significantly predicted the probability of non-abstinence ($p < .05$) and the

probability of alcohol-related problems ($p < .05$). As the level of pretreatment psychopathology increased, the probability of relapse increased in IGT patients and decreased in CST patients.

When dichotomous outcomes (abstinence/non-abstinence, alcohol-related problems/no alcohol-related problems) were analyzed using logistic regression, the interaction of treatment type with sociopathy significantly predicted relapse as defined by non-abstinence ($p < .01$), and occurrence of alcohol-related problems ($p < .05$). As the level of pretreatment sociopathy increased, the probability of relapse increased in IGT patients and decreased in CST patients.

The results of logistic regression also indicated that the level of neuropsychological functioning interacted with treatment type as a significant predictor of alcohol-related problems ($p < .01$). However, the direction of the results was surprising. Nonimpaired patients were less likely to report problems following the coping skills treatment and impaired patients were less likely to report problems following the interactional treatment.

In summary, coping skills treatment became more effective as the patients' level of sociopathy and psychopathology increased. Interactional treatment was more effective for patients with low levels of sociopathy and psychopathology. Contrary to the predicted outcome, neuropsychologically impaired patients did better in IGT, whereas nonimpaired patients did better in CST. The researchers speculated that the task of coping skills acquisition was too demanding for neuropsychologically impaired patients and less effective than

the supportive atmosphere of interactional treatment.

Results of this study should only be generalized to patients who have gone through similar inpatient aftercare programs. The multiple interventions involved in primary treatment were discussed but not examined. In addition, the researchers did not mention whether or not other treatments (e.g., family therapy, AA) were continued concurrently with aftercare. Future research should investigate the effects of CST and IGT within homogeneous groups to determine if their impact is different when group members have similar characteristics.

Cooney, Kadden, Litt, and Getter (1991) followed up the previous research of Kadden et al. (1989). They examined the loss of therapeutic gains two years following group treatment for alcoholism. Additional posttreatment data collections occurred at 12 and 24 months following the beginning of aftercare. Eleven of the 96 subjects were unavailable at the 12 month follow-up, and 20 subjects were unavailable at the 24 month collection. A repeated-measures analysis of variance showed no main effect for treatment type. However, a significant main effect for time, with more frequent heavy drinking at pretreatment than at any of the follow-up points, was found ($p < .001$).

Scores above or below .29 on the ASI Psychiatric Severity subscale were classified as high or low psychopathology, respectively. Survival analysis, a statistical operation which takes time into account, showed psychiatric severity with treatment type to predict time until the first heavy drinking day ($p < .02$). Patients matched according to the previously

stated hypotheses (high psychopathology with CST, low psychopathology with IGT) had longer periods of abstinence, which continued to the 24-month follow-up ($p < .05$).

Similarly, the interaction of sociopathy with treatment type predicted time until the first heavy drinking day. Matched patients (e.g., CST for high sociopathy patients and IGT for low sociopathy patients) maintained sobriety longer than those not matched ($p < .05$). These results also continued to the 24-month follow-up.

The interaction of cognitive impairment with treatment type also predicted the time until the first heavy drinking day ($p < .05$). Cognitively impaired patients treated with CST were the first to relapse; those treated with IGT were the last to relapse. The duration of sobriety for patients who were not cognitively impaired fell after the impaired patients who received CST, and before those who received IGT. As stated regarding the Kadden et al. (1989) study, results of this study should only be generalized to patients who have gone through similar inpatient aftercare programs. Also, the multiple interventions involved in primary treatment were discussed but not examined. And lastly, the researchers did not mention whether or not other treatments (e.g., family therapy, AA) were continued concurrently with aftercare.

Getter, Litt, Kadden and Cooney (1992) developed a rating scale to assess the distinctiveness of the cognitive behavioral coping skills therapy from the interactional therapy treatment. The Group Session Rating Scale (GSRS) was used to examine seven group therapy activities used with newly abstinent alcoholics: problem solving education and skill

training, role playing, identifying high-risk situations, interpersonal learning, exploring and expressing feelings, and here-and-now focus.

Graduate students in psychology rated the seven activities using the GSRS. They listened to 1-minute segments taken during the middle of the first and the second half of group therapy sessions. The raters recorded the prevalence of each activity during the 1-minute blocks.

Using Cronbach's alpha-coefficient, results show high interrater reliability among all seven activities with a range of .83 to .97. Identifying high-risk situations was the exception. The groups were shown to conduct significantly different activities. Pearson's correlations showed that the activities specific to the therapies studied were positively correlated with one another (CST activies, $\underline{r}$ = .60; IGT activiies, $\underline{r}$ = .81). Correlations also showed the activities of the two treatment conditions to be negatively correlated with activities specific to the other therapy. These results supported the validity of the rating system.

Spearman rank order correlations supported previous analyses in finding that no group activity was significantly correlated with abstinence as measured by the Time-Line Follow-Back Assessment (Sobell, Maisto, Sobell, Cooper, Cooper, & Sanders, 1980). The number of education and skills training behaviors was positively correlated with number of group members reporting no drinking related problems ($\underline{r}_s$ = .62). On the other hand, the occurrence of exploring or expressing feelings and here-and-now focus behaviors was negatively correlated with members reporting no drinking-

related problems (r_s = -.81). Based on these findings, the researchers suggested that newly abstinent alcoholics in this study were not ready to manage effectively the consequences of intensive here-and-now interaction and heightened emotional expression. The number of subjects in this study was small and the primary purpose of this study was to establish the validity and reliability of the rating system. Replication of this study is needed with more subjects, which would strengthen the external validity and usefulness of the rating system.

In an effort to elaborate the clinical significance of treatment matching theories, Litt, Babor, DelBoca, Kadden, and Cooney (1992) examined the data of previous research (Kadden et al., 1989) based on alcoholic typologies (Type A and Type B) as developed by Babor et al. (1992). Type A alcoholics were characterized by late onset, fewer indicators of childhood and familial vulnerability, less psychiatric disturbance, less alcohol addiction symptom severity, and good prognosis. Type B alcoholics were characterized by early onset of problem drinking, rapid progression, many indicators of childhood and familial vulnerability, more psychiatric disturbance, greater alcohol addiction symptom severity, and poor prognosis.

The sample included the 66 men from the Kadden et al. (1989) study who had attended 3 or more group sessions and who were determined to have been positively affected by treatment. Measures of vulnerability and risk factors included a Family History Interview (Hesselbrock, Stabenau, Hesselbrock, Meyer, & Babor, 1982), an abbreviated version of the MacAndrew Alcoholism Scale (MacAndrew, 1965), the Drinking History

Questionnaire (Hesselbrock, Meyer, & Keener, 1985), and a conduct disorders symptom count taken from the Diagnostic Interview Schedule (Robins, Helzer, Croughan, & Ratcliff, 1981). Patterns of use of alcohol and other drugs were measured using the Time-Line Follow-Back Assessment (Sobell et al., 1980), the Addiction Severity Index, developed by McLellan et al. (1980), and the Last Six Months of Drinking Questionnaire (Hesselbrock, Babor, Hesselbrock, Meyer, & Workman, 1983). Chronicity, severity, and health consequences of drinking were measured using the Symptom Checklist 90 (Derogatis et al., 1976), alcohol abuse questions from the Diagnostic Interview Schedule, the Subjective Dependence Questionnaire (Heather, Rollnick, & Winton, 1983), and a calculation of the number of years the patient had been drinking heavily. Psychiatric symptoms were measured using the Taylor Manifest Anxiety Scale (Taylor, 1953) and by separate counts of depressive symptoms and antisocial personality traits from the Diagnostic Interview Schedule. Posttreatment data were collected immediately following completion of the 6 and 1/2 month aftercare treatment, and again 12 months and 24 months after inpatient discharge.

A repeated-measures ANCOVA was conducted to test the following hypotheses: (a) Type B alcoholics will have better outcomes with coping skills training (CST), and (b) Type A alcoholics have better outcomes with interactional group treatment (IGT). Patients receiving CST were compared with those receiving IGT, type A patients were compared with type B patients, and hypothesized "matches" were compared with "mismatches". These analyses showed that matches had better

treatment outcomes than mismatches ($p < .05$), with the relationship extending throughout the 18 month follow-up period. Results of other comparisons were not significant.

Survival analyses were also performed to see if "mismatched" patients relapsed sooner than "matched" patients. Relapse was identified in two ways: (a) time until two consecutive light drinking days (no more than two conventional drinks), and (b) time until first heavy drinking day (more than six drinks). Using a proportional hazards (Cox regression) model, results showed that mismatched patients tended to have two consecutive drinking days sooner than those matched to treatment ($p < .02$). Results were not significant when relapse was defined as time to first heavy drinking day.

Repeated measures of analyses of covariance (ANCOVA) detected significant differences in posttreatment drinking attributable to patient type, treatment approach, and an interaction of patient type with treatment. A significant time effect was found, suggesting that drinking levels generally increased over the follow-up periods ($p < .001$). Type B alcoholics showed more heavy drinking days than type A alcoholics over the three posttreatment assessments ($p < .05$). Additionally, Type B alcoholics who received interactional treatment fared worse than the rest of the patients ($p < .05$).

The researchers concluded that patient typology which classifies patients according to vulnerability, course, and severity interacts with treatment approach to predict drinking outcome. However, since it was unclear whether or not the typology hypotheses were superior to the treatment-matching hypotheses, the present typology was tested against the

variables that were predictive in the Kadden et al. (1989) treatment-matching study: psychiatric severity and sociopathy.

The same cutoff points of the ASI Psychiatric Severity subscale and scores on the California Psychological Inventory Socialization scale (CPI-So) were used to dichotomize patients on psychiatric severity and sociopathy, respectively. When the three variables (patient type, CPI-So, and ASI Psychiatric Severity level) were simultaneously entered into logistic regression analyses, no single variable emerged as a significant predictor of abstinence or problem outcomes. However, both patient type and sociopathy interacted with treatment approach to predict posttreatment abstinence. The multi-dimensional typology by Babor et al. (1992) was not more effective in matching patients to interactional or coping skills groups than the single measure of sociopathy. Like the Kadden et al. (1989) study, results of this study should only be generalized to patients who have gone through similar inpatient aftercare programs. Also, the multiple interventions involved in primary treatment were discussed but not examined. And lastly, the researchers did not mention whether or not other treatments (e.g., family therapy, AA) were continued concurrently with aftercare..

Kadden, Litt, Cooney and Busher (1992) further examined treatment matching of aftercare patients. They hypothesized that the use of live role-play situations to facilitate acquisition of coping skills would result in a decrease in urge to drink and reduction in heavy drinking. Additionally, Kadden, et al. investigated whether or not pretreatment role-playing would interact with communication skills training

(CST) and interactional group therapy (IGT) to affect treatment outcomes. If so, patients could be matched to treatments according to their role-play performance scores.

The subjects had completed a 21-day group therapy inpatient drug and alcohol treatment program, and then participated in aftercare group therapy. Patients who had consented to participate in the study were randomly assigned to CST or IGT. The following three types of role-play scenes were administered before and after their 6-month aftercare treatment period, and at 6, 12, and 18 months following completion of the aftercare program: (a) the Alcohol Specific Role Play Test (ASRPT), developed by Abrams, Binkoff, Zwick, Liepman, Nirenberg, Munroe, & Monti, (1991); (b) the Simulated Social Interaction Test (SSIT), developed by Curran, (1982); and (c) the Drink Refusal Scene (DRS), developed by Binkoff, (1985).

The ASRPT (Abrams et al., 1991) was composed of 10 high-risk for drinking situations. Patients role-played responses to the situations either in the presence of a research assistant (interpersonal, five scenes) or alone (intrapersonal, five scenes). Four of the scenes which did not deal with alcohol-related coping skills were omitted from the analysis, leaving six which were alcohol-related and dealt with leisure skills, social competence, habitual drinking situations, conflict, cravings, and alcohol as chemotherapy when feeling jittery.

The SSIT (Curran, 1982) consisted of four social-competence interactions in nondrinking situations: confrontation, interpersonal warmth, interpersonal loss, and

receiving compliments. Additionally, the DRS (Binkoff, 1985) was administered, in which the subject had to refuse the offer of a drink.

Patients used an 11-point Likert scale (1 = no urge at all, to 11 = strong urge) to rate their urge to drink following role-play scenes. The scenes were videotaped. Trained observers rated each patient's anxiety and skill in the role-plays using the same Likert scales. The measures (urge, anxiety, and skill) were found to be sufficiently independent of one another and were treated separately in the data analyses.

Results of the multivariate analyses of variance (MANOVA) showed no significant main effects for treatment type, but did find a decrease in self-reported urge to drink between the pretreatment and posttreatment administrations of the ASRPT ($p < .001$) and the SSIT ($p < .001$). Additionally, significant partial correlations were found between self-reported urge to drink and number of heavy drinking days from pretreatment to all four follow-up points for both the ASRPT and the SSIT ($p \leq .05$).

Hierarchical logistic regression analyses was used to test whether or not role-play variables would interact with treatment type to predict abstinence or nonabstinence at posttreatment. Three of nine analyses produced a significant interaction between treatment type and a pretreatment role-play measure. Observer ratings of subject's skill and self-reported urge to drink during the Drink Refusal Scene interacted with treatment type to predict abstinence at posttreatment ($p < .02$). Also, observer-rated anxiety in the

ASRPT interacted with treatment type to predict abstinence at posttreatment ($p < .04$). Patients who were rated as having more skill, lower anxiety, or who reported lower urge to drink, and who were assigned to the interactional treatment were more likely to be abstinent at the end of aftercare ($p < .05$). Those rated as having poorer role-playing skills or greater anxiety had better outcomes when treated in the coping skills groups ($p < .05$). Those reporting high urge to drink had similar probabilities of relapse regardless of the treatment received ($p < .05$). Results were also significant when the analyses were repeated to examine the interactions with treatment types through the two year follow-up period ($p < .05$).

Further analyses were conducted to rule out any interactions with sociopathy, previously found to interact with treatment type, and the urge to drink rating of the Drink Refusal Scene (Kadden et al., 1989). There was no interaction of the urge to drink rating and sociopathy with treatment type. Also, over the 2-year follow-up period, patients with low urges in the Drink Refusal Scene who were assigned to interactional treatment and those with high urges assigned to the coping skills treatment had the best outcomes. Low anxiety patients assigned to the coping skills group had the worst outcomes.

In terms of clinical applicability, the prospect of the Drink Refusal Scene predicting outcome in treatment matching is promising. However, it has not been demonstrated that this measure is superior to the measure of sociopathy previously identified by Kadden et al. (1989). In light of treatment

expense, it remains to be seen if the predictive value of the sociopathy measure outweighs the cost and time of role-playing.

Kadden, Litt, and Cooney (1994) further explored the data provided by the Kadden et al. (1989) project. They sought to determine if the matching effects were mediated by attendance at treatment sessions, group process variables, or other therapeutic activities in which the patients engaged while the study treatments were going on. After the 3rd, 12th, and 26th aftercare sessions, patients completed the Group Environment Scale (GES), developed by Moos (1981), which measures group process variables. The GES variables include Cohesion, Leader Support, Expressiveness, Independence, Task Orientation, Self-discovery, Anger/Aggression, Order/Organization, Leader Control, and Innovation.

Regression analyses results indicated that patients who attended more treatment sessions went longer without relapsing. However, this occurred across both treatment groups, indicating no interaction of attendance with type of treatment. Regression analyses also produced significant findings regarding relationships between group process and outcome.

Survival analyses found main effects for GES client ratings of group Cohesion and Leader Support as predictors of time to first heavy drinking day ($p < .05$), with higher ratings predicting longer sobriety. Higher ratings of Expressiveness were associated with longer time to relapse after interactional group therapy (IGT), and shorter time to relapse after coping skills therapy (CST; $p < .02$).

The analyses of relationships between ancillary treatments and the outcome produced no significant differences between patients assigned to the CST groups and IGT groups in their utilization of individual counseling or Antabuse ($p < .02$). However, a significantly greater number of CST patients attended AA meetings compared to patients assigned to IGT ($p < .05$). In general, those who scored higher in sociopathy attended more self-help meetings ($p < .05$).

Results also found that utilization of the ancillary treatments did not produce significant differences in heavy drinking days or in heavy drinking at any of the follow-up points. The interactions previously noted between CPI-So or ASI-Psychiatric Severity and treatment type were not reduced when the analyses controlled for the use of the ancillary treatments. That is, the utilization of ancillary treatments did not effect treatment outcome or the treatment-matching findings. The researchers speculated that these results were due to the patients' self-selection regarding participation in ancillary treatments. They encouraged future study of patients matched to homogeneous treatment groups at the outset of treatment.

In summary, CST appears to be the clinical intervention of choice in aftercare with patients who have high sociopathy or psychopathic severity indices at pretreatment. IGT appears to be the clinical intervention of choice with patients who have low sociopathy, low psychopathology, or cognitive impairment.

The typology of Babor et al. (1992) and the factors of anxiety, skill, and urge to drink during role-play identified

by Kadden et al. (1992) appear helpful in matching patients to aftercare group treatments. However, these factors have not been proven superior to level of sociopathy for use in the treatment matching process.

Cohesion and Leader Support were also identified as therapeutic predictors of heavy drinking. Higher Cohesion and Leader Support was associated with longer time before relapse. Expressiveness in interactional group may also delay relapse, but was only clinically significant and not a statistically significant outcome predictor. Additionally, participation in ancillary treatments did not appear to affect treatment-matched outcomes.

Conclusions

This paper reviewed the research regarding therapeutic factors of group psychotherapy for adult alcoholics. The research reviewed suggests that treatment outcome is affected by the types of intervention employed during all phases of the treatment process. Orientation groups, treatment matching, and transition groups all appear to improve outcome.

Treatment for alcoholism appears to be moving away from the use of similar interventions with all alcoholic patients toward patient-treatment matching. This movement seems to be supported by the variety of treatments proving effective with patients of differing characteristics or from specific populations. These results were found even when treatment matching was not the focus of the study. Further study of treatment matching may provide information which will enable providers to maximize treatment efficacy for alcoholic

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patients.

The reviewed studies were often limited to specific populations in specific settings. As a result, many threats to external validity exist. Replication of research is needed with more heterogeneous populations and larger samples. Studies should also be expanded to include patients from inpatient, outpatient, and day hospital settings. This research strategy would strengthen the external validity of any findings.

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